9. ALTERNATE BILLING SYSTEM (ABS) ARRANGEMENTS

9.1 OVERVIEW

ABS is an alternative billing arrangement to the fee-for-service claiming system. An ABS arrangement must be requested and performed under the auspices of an institution, with the administration of the institution required to accept responsibility for assuring that services are organized and performed as approved.

9.2 REQUEST AND APPROVAL OF ABS ARRANGEMENTS

To apply for a new ABS arrangement, a request must be submitted by the administration of the institution to the Assistant Director of Physician Services. The request should provide as much information as possible to allow MCP to properly evaluate the need for the arrangement. Information such as population figures, historical statistics, or other special circumstances should be made known to assist in the evaluation.

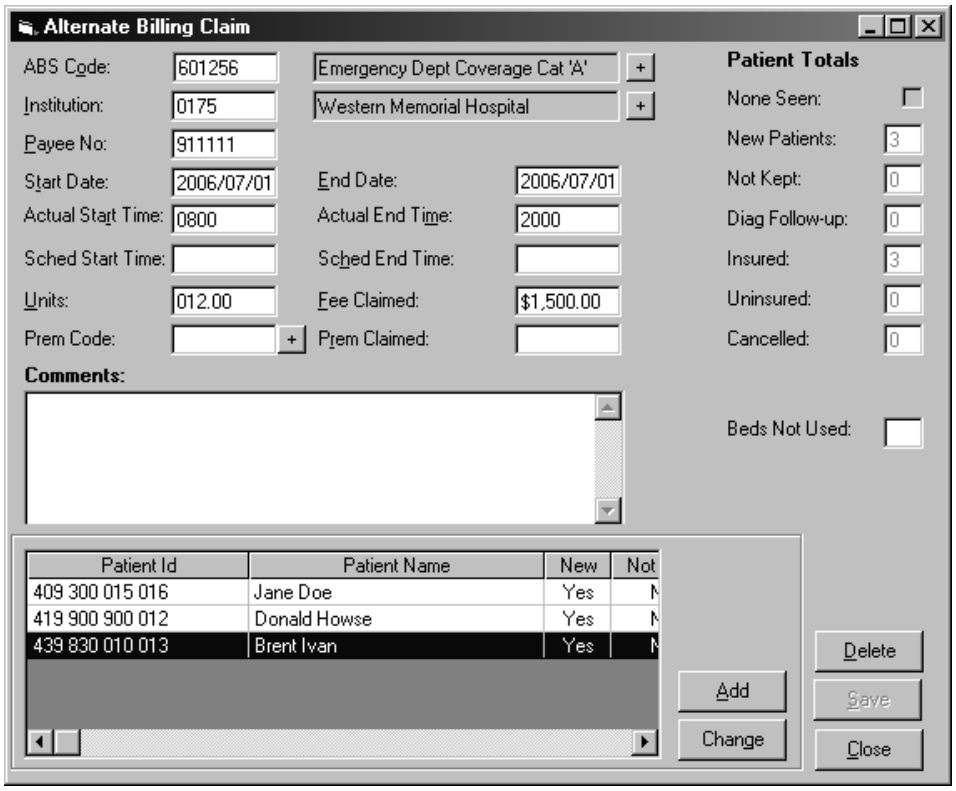
If approved, the Director of Physician Services will advise the institution of the approved session frequency, rate, and budget. An ABS number will be assigned which must be quoted on all claims for that ABS arrangement. Proper management of session utilization is paramount to ensure that the arrangement is used most efficiently and continues where practical.

9.3 APPROVED TYPES OF ALTERNATE BILLING ARRANGEMENTS

9.3.1 On-Site Emergency Coverage—Category A Facilities

- This billing arrangement provides payment to General Practitioners and Specialists for 24-hour coverage in Category A emergency department facilities.
- The physician must be eligible for fee-for-service billing. If salaried, approval for temporary fee-for-service billing must be given by the Medical Director. A "Request for Approval for Temporary Fee-for-Service Billing by a Salaried Physician" form must be submitted by the Regional Integrated Health Authority.
- Only one physician may bill a shift, with exception of the Health Sciences Centre and St. Clare's Mercy Hospital. Both hospitals have been approved for double physician coverage based on patient volume and acuity level.
- Billing for patients seen on a fee-for-service basis is not permitted.
- Rate—please refer to the MCP Payment Schedule, General Preamble, for the approved hourly rate.
- A list of approved Category A facilities can be found in the MCP Payment Schedule's General Preamble and Appendices.

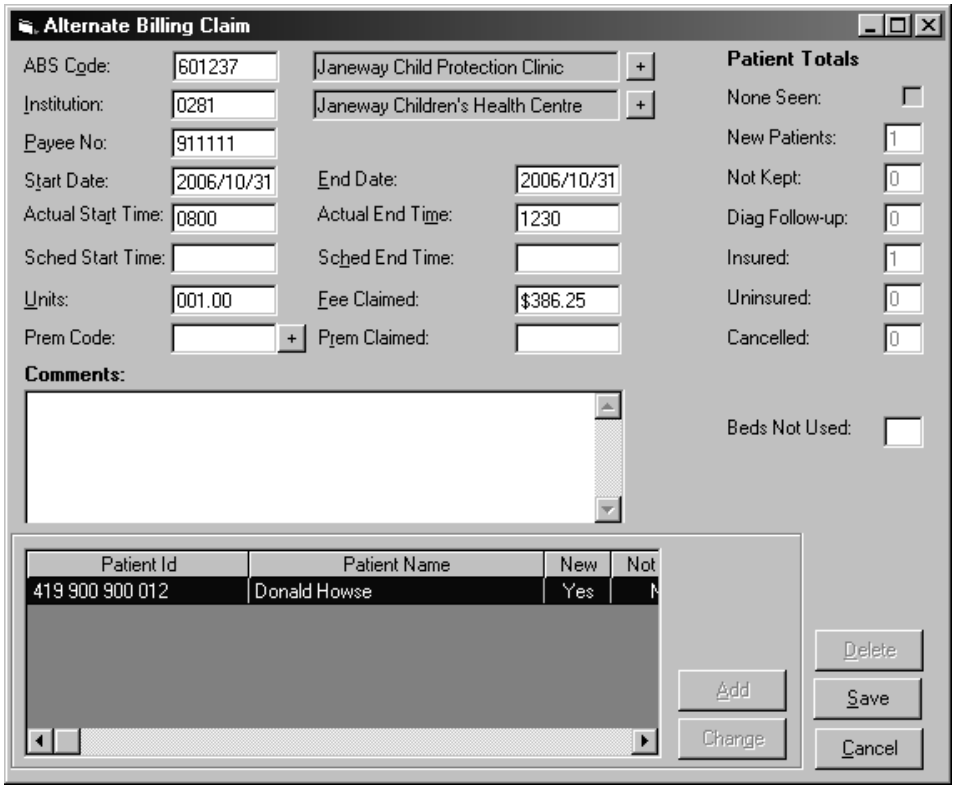
Example of Emergency Room (Category 'A') Electronic Claim



9.3.2 Organized Clinics—Janeway/Children's Rehabilitation/Cancer Clinic

- It is designed to make it financially feasible for physicians to render services in circumstances where the number of patients and time involved would not provide a reasonable remuneration on a fee-for-service basis.
- This arrangement provides payment to Specialists for time "set aside" or "dedicated" for clinics.
- Approval must be given by MCP for physicians to bill for these clinics. A written request from the institution's administration must be submitted to the Director, Medical Services or Assistant Director, Medical Services.
- Physicians have the option to bill either fee-for-service **or** alternate billing for the duration of a clinic. However, emergency services that result from physician's on-call commitment, which occur during "committed fee-for-time", may be submitted I.C. for consideration of payment.
- Rate—clinics are paid based on "units" worked. Please refer to the MCP Payment Schedule, General Preamble, for the approved rates.

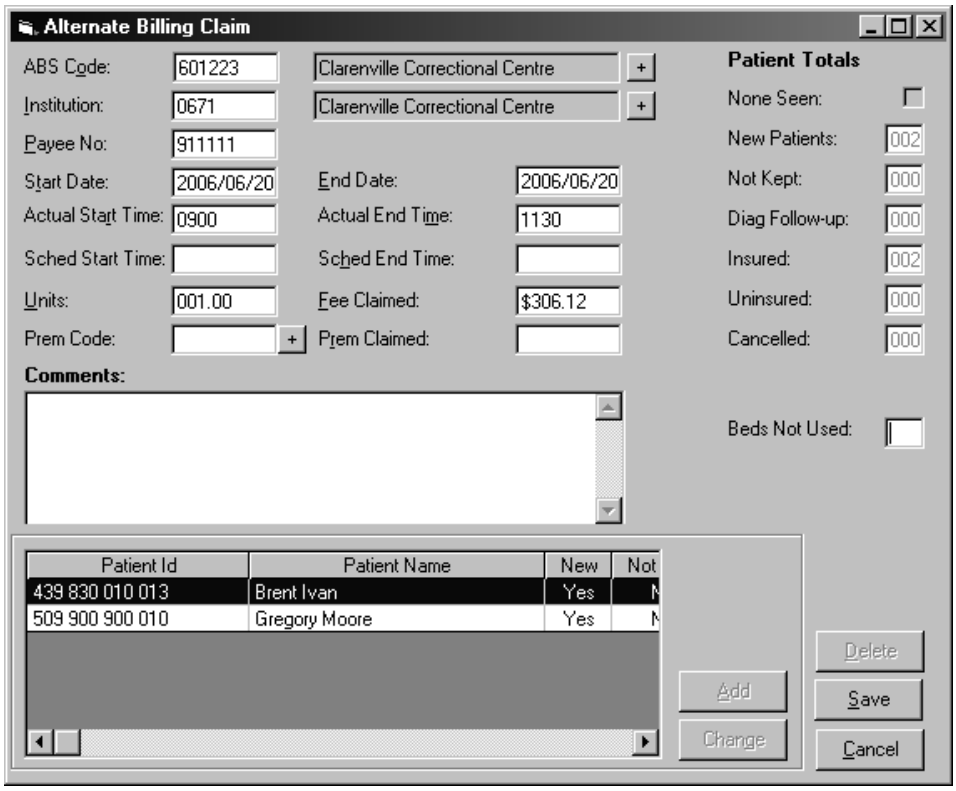
Example of Organized Clinic—Janeway Child Protection Electronic Claim



9.3.3 Organized Clinics—Correctional Institutions

- This arrangement provides payment to General Practitioners for time "set aside" or "dedicated" for clinics.
- The physician must be eligible for fee-for-service billing.
- Approval must be given by MCP for physicians to bill for these clinics. A written request from the institution's administration must be submitted to the Director, Medical Services or Assistant Director, Medical Services.
- Physicians have the option to bill either fee-for-service **or** alternate billing for the duration of a clinic.
- Rate—clinics are paid based on "units" worked. Please refer to the MCP Payment Schedule, General Preamble, for the approved rate.

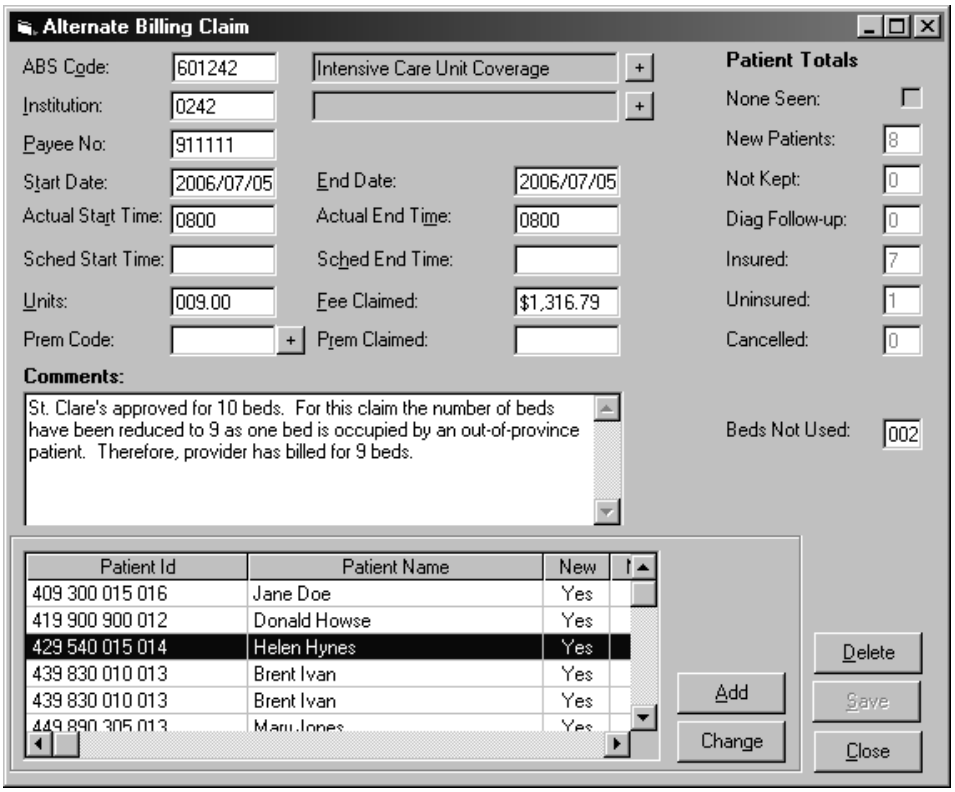
Example of Organized Clinic—Correctional Institution Electronic Claim



9.3.4 Dedicated On-Site 24-Hour Intensive Care Unit Coverage

- This arrangement is for the claiming of "dedicated", on-site, ICU services at facilities designated by the DOHCS. These facilities are St. Clare's Mercy Hospital and the Health Sciences Centre. Payment is provided to specialists only.
- Physicians must be eligible for fee-for-service billing.
- Approval must be given by MCP for providers to bill for these clinics. A request from the institution's administration must be submitted to the Director, Medical Services or Assistant Director, Medical Services.
- Payment of the 24-hour coverage for each facility is based on the number of designated beds multiplied by the applicable daily bed rate.
- For claiming purposes, the 24-hour coverage starts at 8 a.m.
- If anytime, during a 24-hour period, a bed is occupied by a non-Canadian, out-of-province, or third party patient, the claim for payment should be reduced by the value of the daily bed rate multiplied by the number of such patients.

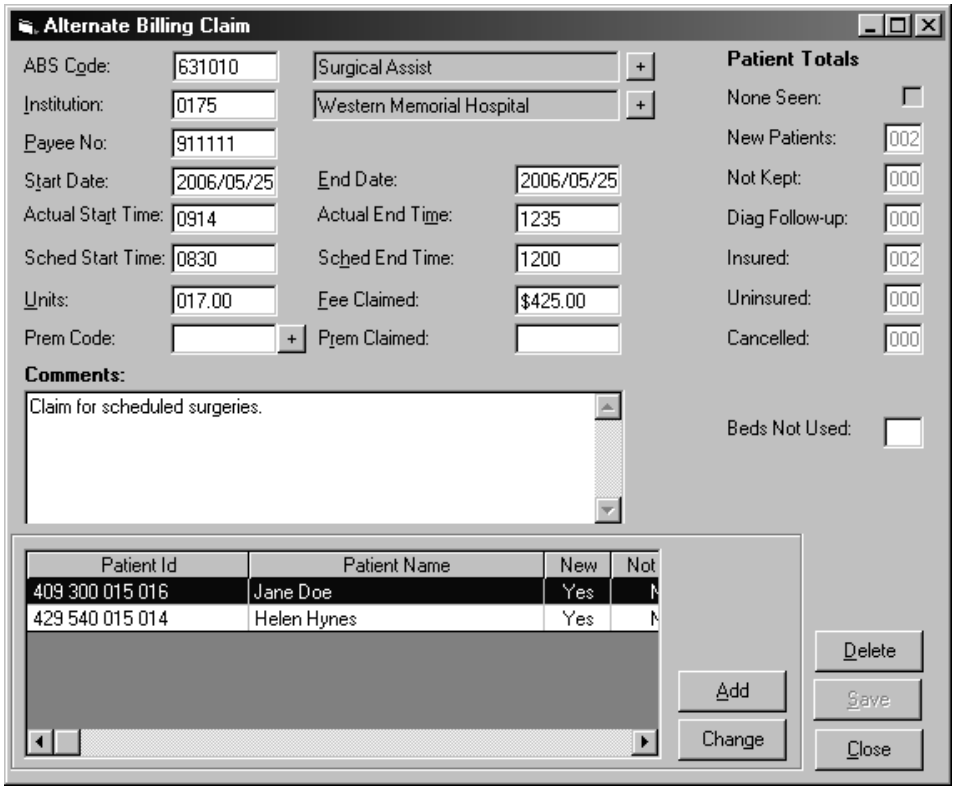
Example of Intensive Care Unit Coverage Electronic Claim



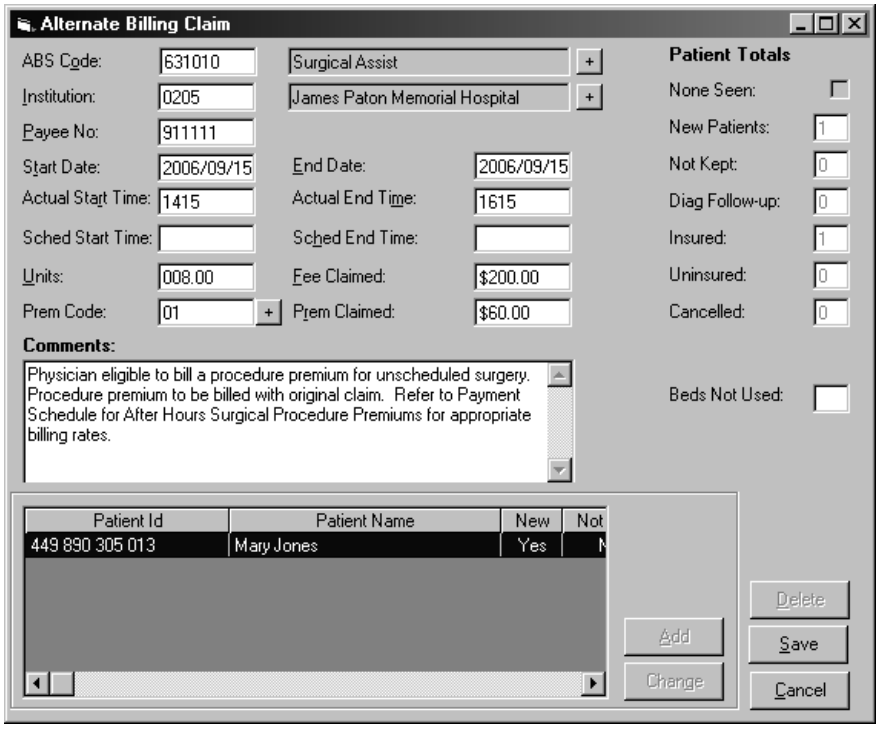
9.3.5 Surgical Assist—Dedicated Time Method

- This arrangement provides payment to General Practitioners who assist in surgical procedures.
- Physicians must be eligible for fee-for-service billing.
- The period of time claimed as "dedicated" time must be continuous and cannot be interrupted time. Payment is made for the greater amount of time, regardless of whether it is scheduled time or actual time, or a combination of both.
- Actual time spent assisting at non-MCP insured procedures, eg. WHSCC or out-of-province patients must be subtracted from the time claimed as "dedicated" time.
- Rate—there is a flat rate per 15-minute period, with the last unit of time payable as a complete unit, for any utilized portion of the 15-minute period.
- Procedures which are unscheduled and occur in the premium hours are eligible for payment of both visit and procedural premiums. See MCP Payment Schedule, Visit Premiums, for a list of visit premiums and rates (please note that Assistant must actually see the patient before billing this premium). See MCP Payment Schedule, Surgical Premiums, for a list of procedural premiums and rates.
- For billing purposes, when billing an unscheduled surgery the procedure premium must be billed with the original claim with time units and fee claimed; the visit premium must be billed as a separate claim (see following examples).

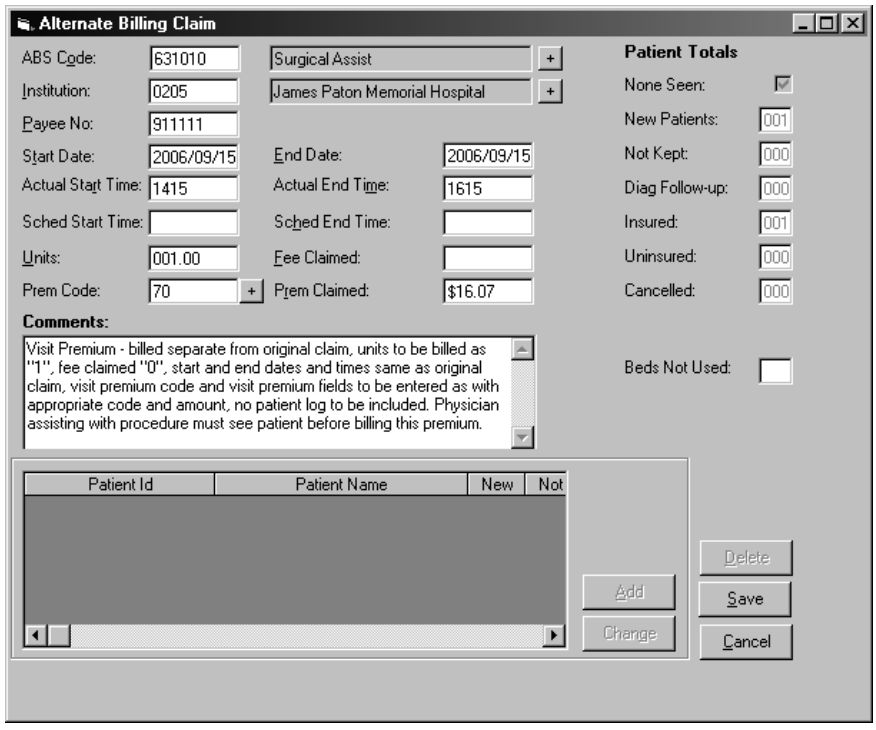
Example of Scheduled Surgeries Electronic Claim



Example of Unscheduled Surgery Electronic Claim with Procedure Premium



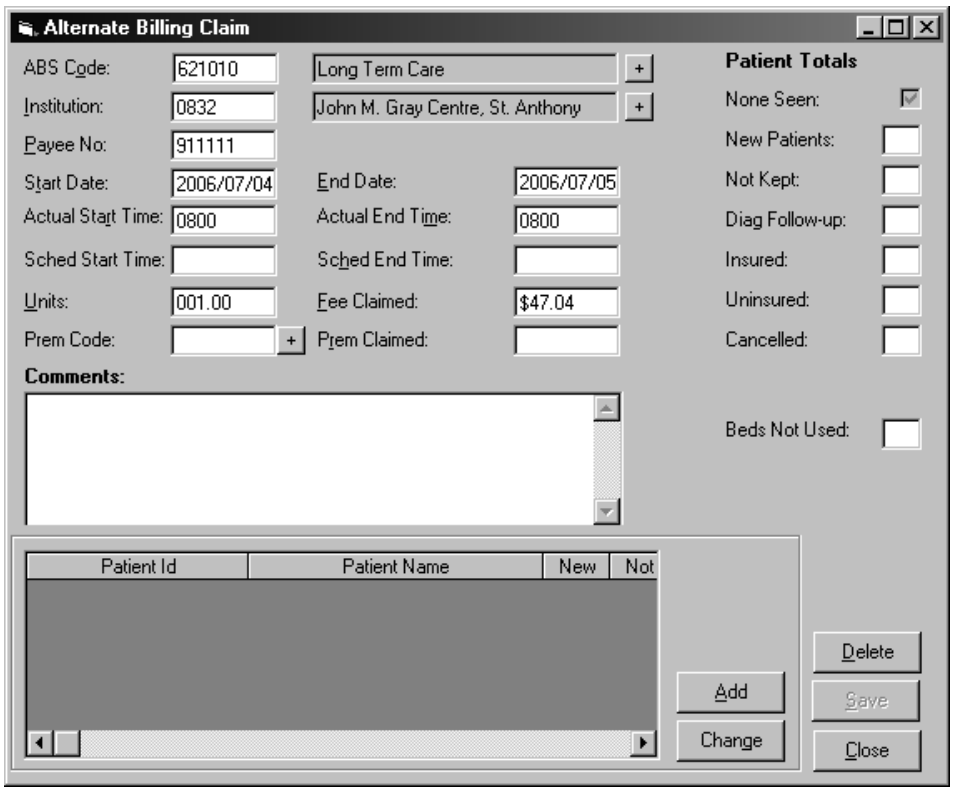
Example of Visit Premium Claimed for Unscheduled Surgery Electronic Claim



9.3.6 Long Term Care Facility Coverage

- This arrangement provides payment to General Practitioners for 24-hour coverage to residents in DOHCS designated long term care facilities with long term care beds. A physician who provides clinical services and coverage to these designated facilities is eligible for payment of a per diem fee.
- To qualify for the per diem, physicians must provide comprehensive 24-hour coverage for all medically necessary services to the facility. The hours of coverage begin at 0800 and end at 0800 the following date—7 days per week.
- Direct patient care visit(s) to these facilities can be claimed on a fee-for-service basis and paid in addition to the per diem. These services must be claimed using the DOHCS designated long-term care visit fee codes for General Practice. The Home's facility number must be entered on claims for these services.
- Coverage must be provided at a facility which has been designated by the DOHCS. A list of approved Long-Term Care facilities can be found in the MCP Payment Schedule's General Preamble and Appendices.
- Rate—the rate payable is unique to each facility, as listed in the MCP Payment Schedule's General Preamble and Appendices.

Example of Long-Term Care Facility Coverage Electronic Claim



9.3.7 Emergency Department Coverage—Category B Facilities

- This arrangement provides payment to General Practitioners for off-site coverage of emergency departments in facilities that offer 24-hour emergency services.

- A list of approved Category B facilities can be found in Appendix B of the MCP Payment Schedule's General Preamble.

- Payments for daytime Emergency Department (ED) coverage, 8 a.m. to 6 p.m. Monday to Friday (Fee Code 611010):
    - Fee-For-Service General Practitioners who are scheduled to immediately respond to the emergency needs of a Category "B" designated facility are eligible to bill an hourly rate of $41.18 in addition to their fee for service billings.
    - Salaried General Practitioners are not eligible to bill fee code 611010.

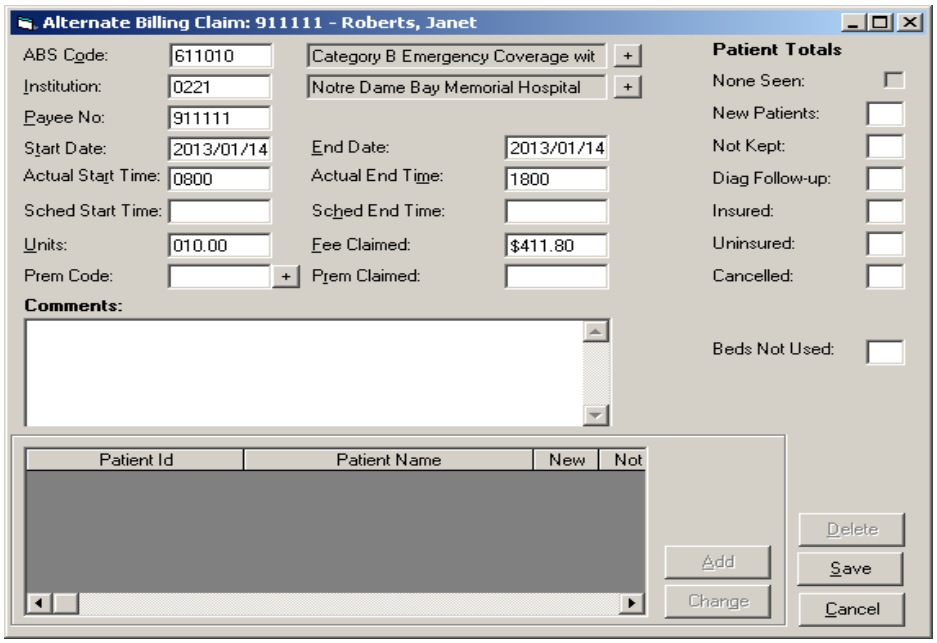
- Payments for after hours ED coverage, 6 p.m. to 8 a.m. Monday to Friday, all day Saturday, all day Sunday and RHA designated statutory holidays (Fee Code 611020):
    - Fee-For-Service General Practitioners who are scheduled to immediately respond to the emergency needs of a Category "B" designated facility are eligible to bill the all inclusive hourly rate of $73.00 (no Fee-For-Service billing in addition) ***or*** the hourly rate of $41.18 in addition to their Fee-For-Service billings;

      NOTE: Choice of payment is at the physician's discretion but must apply for the entire shift or period of ED coverage provided.

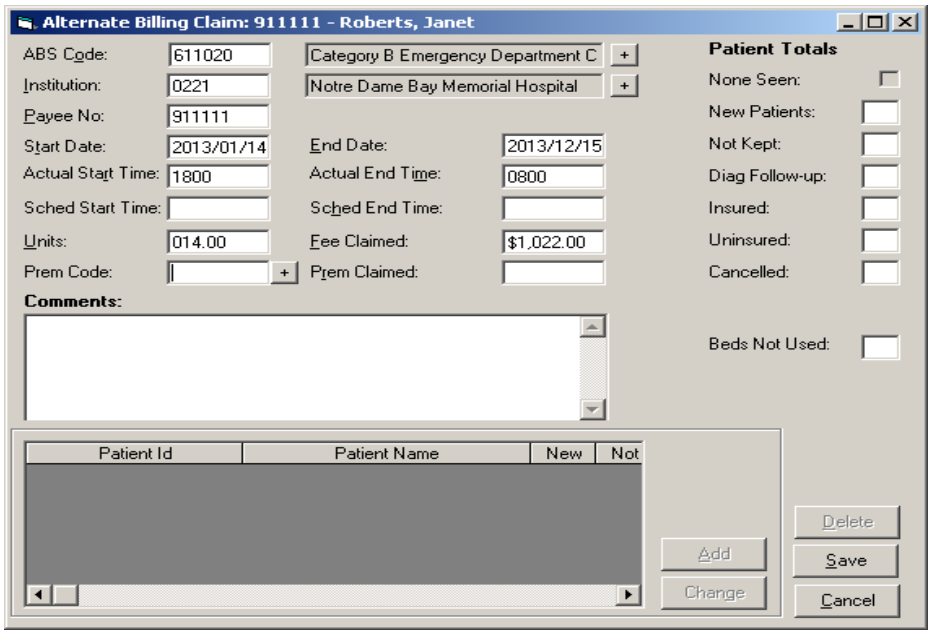
    - Salaried General Practitioners who are scheduled to immediately respond to the emergency needs of a Category "B" designated facility are eligible to bill the all inclusive hourly rate of $73.00 (No Fee For Service billing in addition)

    - Locum General Practitioners who are scheduled to respond to the emergency needs of a Category "B" designated facility are eligible to bill the all inclusive hourly rate of $73.00 (no Fee-For-Service billing in addition).

Example of Emergency Department Coverage – 8 a.m. – 6 p.m. Monday – Friday (Category B Facility) Electronic Claim (Fee Code 611010)



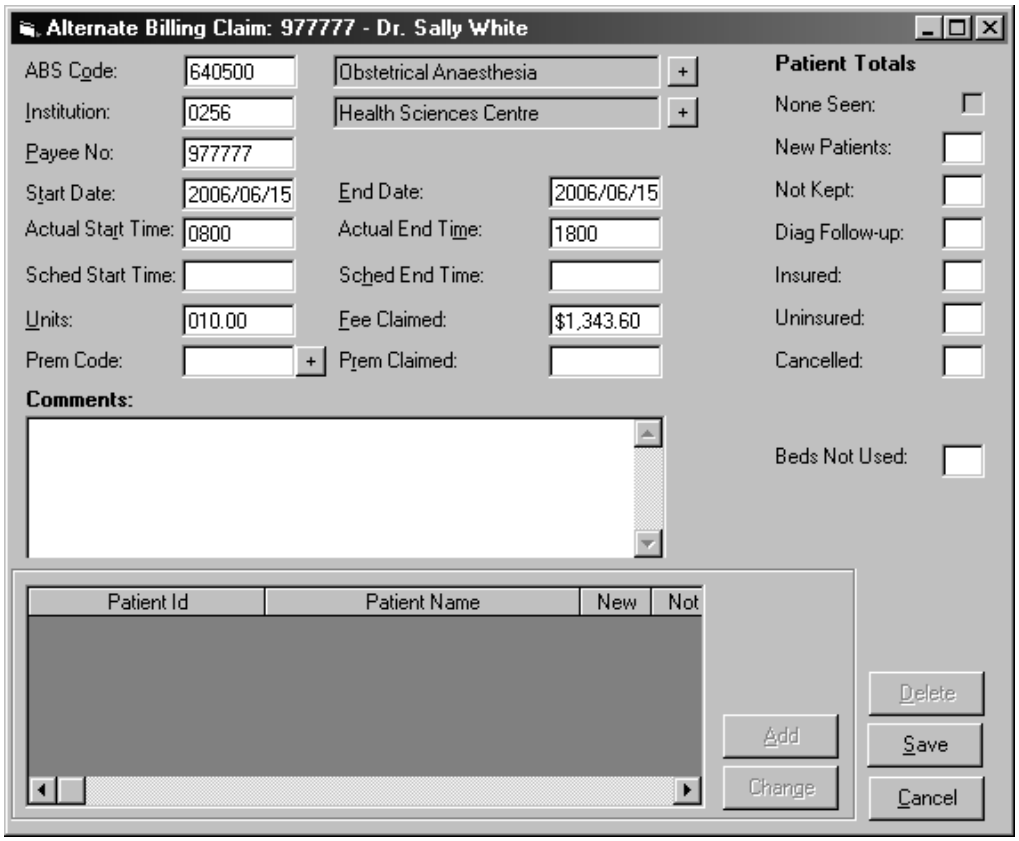
Example of Emergency Department Coverage – 6 p.m. – 8 a.m. Monday – Friday, all day Saturday, all day Sunday and RHA Designated Statutory Holidays (Category B Facility) Electronic Claim (Fee Code 611020)



9.3.8 Obstetrical Anaesthesia

- This arrangement provides payment to Anaesthetists (Specialty 002) for coverage of the Obstetrical Unit at the Health Sciences Centre.
- Physicians must be eligible for fee-for service billing.
- Rate—will be personally communicated to participating physicians from time to time.

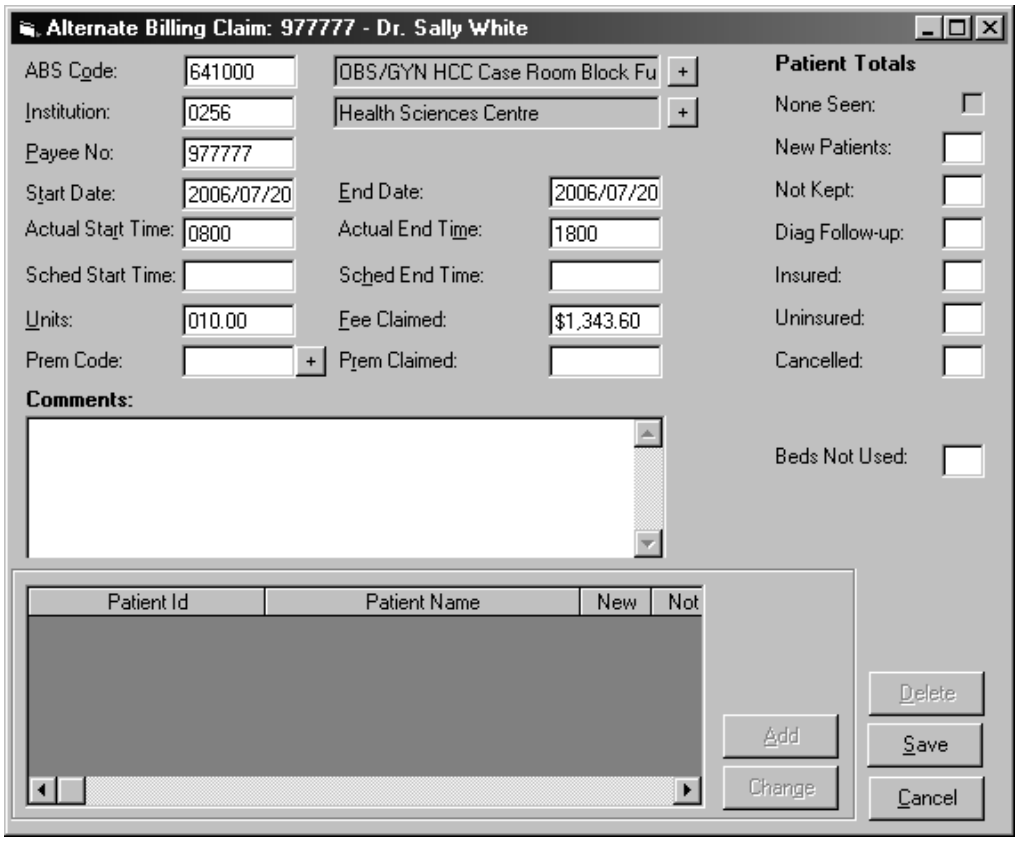
Example of Obstetrical Anaesthesia Electronic Claim



9.3.9 Obstetrical/Gynaecology HCC (Health Care Corporation) Case Room—Block Funding

- This arrangement provides payment to Obstetricians for coverage of on-site case room services at the Health Sciences Centre.
- Physicians must be eligible for fee-for-service billing.
- Rate—will be personally communicated to participating physicians from time to time.

Example of Obstetrical/Gynaecology HCC Case Room Electronic Claim

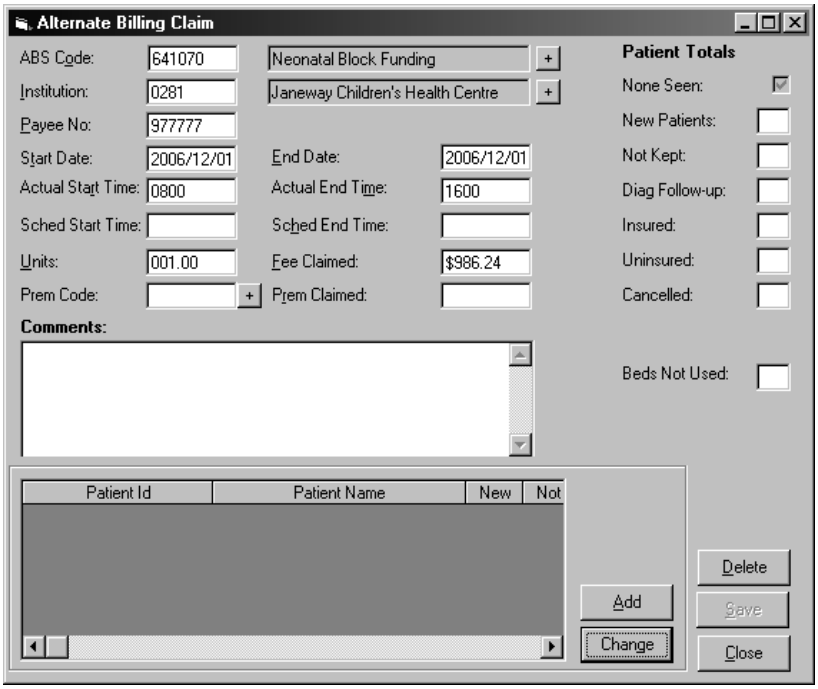


9.3.10 Neonatal Block Funding

- This block funding arrangement provides payment to Paediatricians or Neonatologists who provide services at the Janeway Children's Rehabilitation Centre.
- Physicians must be eligible for fee-for-service.
- Please refer to the most recent correspondence for the current applicable rates.
- There are eight fee codes unique to this arrangement which must be billed as follows:

NEONATAL BLOCK FUNDING					
FEE CODE	LEVEL OF CARE	Weekday 8 am - 4pm excluding HCC holiday	On call, any day 4pm - 8am	HCC holiday 8am - 4pm	Weekend 8am - 4pm
641030	I	Current Rate	N/A	N/A	Current Rate
641040	I	N/A	N/A	Current Rate	N/A
641050	II	Current Rate	N/A	N/A	N/A
641060	II	N/A	N/A	Current Rate	N/A
641070	III	Current Rate	N/A	N/A	N/A
641080	III	N/A	Current Rate	N/A	N/A
641090	III	N/A	N/A	Current Rate	N/A
641100	III	N/A	N/A	N/A	Current Rate

Example of Neonatal Block Funding Claim

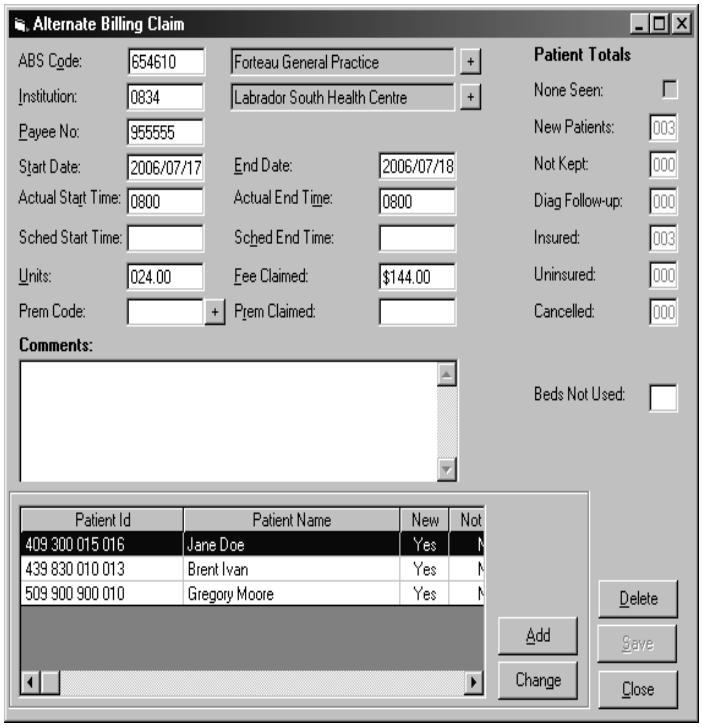


9.3.11 On-Call Payment

- This arrangement provides payment to on-call physicians who are available to respond to urgent or emergent requests to attend a facility for the purpose of examining, treating, or providing diagnostic services to discharged or unattached patients: who present from the community via the emergency department: or who are referred to physicians from other facilities; or who are in-patients admitted to physicians in another specialty.
- Approved on-call rotas must follow a defined call schedule which provides for coverage 24 hours per day, 365 days a year. This can involve locum coverage or cross coverage with another group.
- The on-call services will be based from designated facilities.
- Being on-call for one's own patients, or being on-call for patients admitted to other physicians in the same specialty on-call rota is not sufficient to qualify for an on-call payment under this program. However, physicians may continue to see their own and their specialty group's patients during the period they are on-call for unattached patients.
- Only one on-call payment is payable to a physician for the same time period. If two services are covered, then the higher fee can be claimed.
- The on-call fee may be billed in addition to applicable fee-for-service or salaried payments. The exception to this is fee-for-service physicians claiming Category 'B' Emergency Department Coverage (code 611010) who are paid for call by another mechanism and cannot claim the on-call per diem in addition.
- There can only be a single general practice on-call payment for a given facility. Where there is more than one group, the physicians may decide to divide the on-call fee.
- Call Rotas Providing Continuous Coverage: physicians who participate in call rotas that provide continuous coverage are eligible to bill an hourly per diem.
- Multi-Regional Call Groups: if physicians in a region are unable to provide continuous coverage for an essential service in their region, they may form rotas made up of physicians from two or more regions and provide continuous coverage for those regions.
- Call Back Groups: it is recognized that there are physician groups which provide some services to patients as described in the general definition but are not able or not required to provide coverage 24 hours per day, 365 days per year, or are called very infrequently. They have been designated as "Call Back Groups". Physicians in these groups are not required to maintain a defined 365 day per annum call schedule, but may be asked to urgently attend to an unattached patient on a very infrequent basis. On days when physicians in such groups do respond to one or more such requests, they are eligible to claim a call back fee. The call back fee may be only claimed once on any calendar day.
- Rate—the approved rate payable for Continuous Coverage, Multi-Regional Call Groups, and Call Back Groups can be found in the On-Call Payment Information Manual and will be updated in MCP Newsletters as required.

Example of Hourly On-Call Payment Electronic Claim

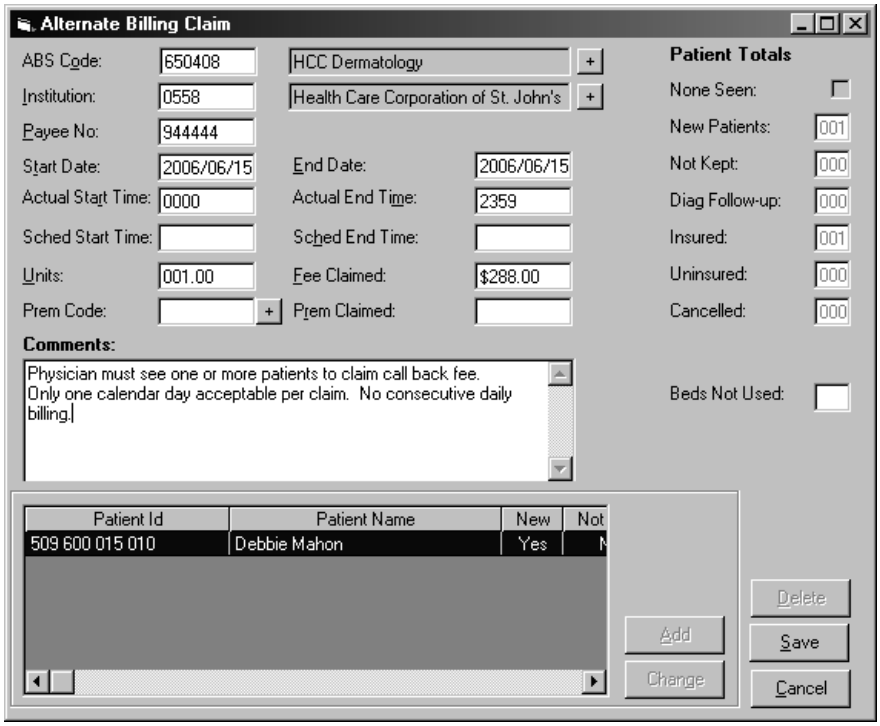
Patient logs are required when patients are seen during an on-call shift.
If no patients are seen, the 'none seen' field must be checked.



Example of Daily On-Call Electronic Claim

For daily on-call claims start and end times must be billed as 00:00-23:59.

Physicians are required to see one or more patients to be eligible to bill daily on-call.



9.4 CLAIM COMPLETION AND SUBMISSION

All physicians are strongly encouraged to bill claims to MCP **electronically**. The current version of MCP TeleClaim software can be used to bill for all approved ABS arrangements. Physicians who use other billing software provided by a private vendor should contact their vendor to discuss conversion to electronic billing.

For physicians who bill using paper claims, each ABS arrangement claim form is pre-numbered with a unique claim number and has a carbon duplicate for physicians to keep for their records. The original form must be sent to MCP; photocopies are not acceptable. A claim must be completed for each session by each physician who rendered services during the session. The original claims, not copies, must be submitted to MCP and must be signed by the physician who performed the services and countersigned by an authorized institution employee who can verify that the services were performed as claimed. Examples of paper claims used for ABS arrangements can be found in Appendix 1—Forms of this manual. Paper claim forms are available upon request from MCP at 1-800-563-1557, (709)292-4000, or (709)292-4015. Please **PRINT** all characters neatly and legibly.

A claim must be submitted within 90 days of the date of service. For ABS arrangements, this is 90 days from the end date of the session. Claims submitted with end dates greater than 90 days will not be accepted unless there are extenuating circumstances which are outlined in a letter accompanying the claim. Late claims submitted without an explanation will be cancelled with a turn around document (TAD) being sent to the physician.

9.5 RETURNED AND REJECTED CLAIMS

Each claim submitted under an ABS arrangement will be subjected to a thorough examination to ensure that the claim is valid. Claims that do not meet the rules established for ABS arrangements will be rejected by MCP=s ABS claims processing system and will result in TADs being sent to the physician for clarification of billing. Claims that are cancelled will require resubmission of a new claim.

Correspondence (queries, cancellation notices, etc.) will be sent electronically to those who submit their claims electronically, and by paper to those who submit paper claims.

9.6 METHOD OF PAYMENT

Claims that meet the validation and assessment criteria will be accepted for payment. After each claim submission deadline, processed claims will be incorporated into the regular fee-for-service claim payment process, and will appear on physicians= remittance statements with the ABS fee code number.

Physicians who submit fee-for-service claims through electronic submission methods should be aware that ABS arrangement claims will appear on the electronic remittance statement even if the ABS claims are submitted on paper.